MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, January 17, 2002
8:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
Adjusting for local differences in resident training costs [mandated study due March 2002]
Craig Lisk

MR. LISK: This probably can be pretty quick. At the last meeting we discussed some analysis that we looked at for adjusting local differences in residency training costs, which part of a report that's required by, or a study that's required by Congress. We have in your briefing materials a draft letter to send to the Congress on the conclusions that the Commission reached at the last meeting. So the purpose today is for you to approve this letter, or if there's any modifications you might to make, to make those modifications.

So briefly, to review what the congressional mandate was, Congress in committee report language in the Balanced Budget Refinement Act of 1999 asked, is the physician GAF an appropriate factor to adjust GME payments for geographic differences in the cost of physician training? They wanted the Commission to make recommendations by March 2002 on a more sophisticated or refined index to adjust direct GME payment amounts, if appropriate. Again I want to say, they wanted the Commission to make a recommendation if appropriate.

Just to briefly review in terms of Medicare's GME payments. GME payments are based on hospital-specific payment rates updated for inflation. The BBRA established a floor and rate of increase ceiling to these amounts so hospitals with low present amounts would get their payments raised. This floor and ceiling is a geographically adjusted national average amount, and the geographic adjustment is the physician geographic adjustment factor used in adjusting physician payment rates.

BIPA raised the floor payment rate to 85 percent of this geographically adjusted national average. So hospitals in between the floor and rate of increase ceiling still get their current hospital-specific per-resident amount. So most hospitals do not receive the same payments as they would without this legislation. The ceiling is a rate of increase ceiling so it just affects -- those hospitals are frozen for two years and have reduced updates in subsequent years.

So in last month's analysis we examined the following geographic adjustment factors and looked at them: the physician GAF, the one that's currently used; the hospital wage index; a resident teaching physician wage index developed from data from the current wage index survey; an index based on per-resident costs or payments; and potentially a composite index of one of these -- two or more of one of the above indices.

In looking at our analysis in terms of -- the next slide summarizes the basic findings from the Commission and what's included in the letter are that we found that resident stipends don't vary tremendously across the country. As you recall, basically the 10th percentile and the 90th percentile only have about a 9 percent difference from what the average is, up or down. New York City is probably the most expensive at about 16 percent or 17 percent above the national average. That's not a

lot of variation when you compare it to what the variation is in the hospital wage index and stuff like that.

The physician GAF though, of all the indices we looked at, is much less variable than other indices. That index is much more of a pure price index in terms of its construction compared to the others.

Using a different index would also change payments for many hospitals without necessarily improving payments. So in terms of one of the factors that we were considering was whether, if we found something different, is it worth the cost of changing, and I think that's one of the conclusions we came to.

Current available data on resident teaching physician costs which might be more reflective of what we're seeing in per-resident payments, the quality of that data is not reliable enough really to develop an effective alternative. And the cost of developing a reliable index based on that data probably outweighs the cost of the potential benefits of such an index for use as it's currently being used.

We do have a paragraph at the end of the letter though that does state that if Congress did move to a national average they might want to reconsider that and have data developed more specifically on resident salaries and teaching physician salaries. It's different from the wage index. Because part of the problem we found with the wage index was that it is hourly wages for residents and what does that really mean when you have residents who are working 80 hours, 60 hours and stuff. But we know the basic salaries don't vary substantially there.

So basically come to the conclusion for the letter is that the physician GAF provides a reasonable method for adjusting floor and rate of increase ceilings for geographic difference in the cost of residency training. So we'd like you to approve the letter, or if there's any modifications, please let us know.

MR. HACKBARTH: Any questions about the letter? I think we actually held a formal vote at the last meeting, didn't we?

MR. LISK: No. That's why --

MR. HACKBARTH: So all in support of the letter, I guess?

DR. ROSS: Comfortable with the conclusion.

MR. HACKBARTH: All opposed to the letter, raise your hand.

All in favor?

Abstain?

Thank you. We were asked by the Congress for our opinion on this and we need to vote on the record and say, this was our opinion.